VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 22, 2014

Ms. Paula Patorti, Administrator
Our House Too Residential Care Home
69 1/2 Allen Street
Rutland, VT 05701

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 24, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 12/01/2014
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING: ______ B. WING ______	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER: OUR HOUSE TOO RESIDENTIAL CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 69 1/2 ALLEN STREET, RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 11/24/14 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100	It is appreciated that per request and in phone call c P. Cota this POC was extended until today 12/17/14 - much appreciation PP	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the RCH failed to assure a written plan for the use of PRN (as needed) psychoactive medication was developed by the RN and provided to staff for the administration of Valium for 1 applicable resident. (Resident #1) Findings include: 1. Resident #1, admitted to the RCH on 11/13/14 with a diagnosis of Dementia, Diabetes, and seizures had a physician order for Valium 5 mg. every 6 hours as needed for anxiety. From 11/14	R167 R167	Behavior flow sheet, written Behavior Plan and Aims are all in place. Hesitation was due to our goal of reducing or eliminating the Valium. Manager and RN are aware that these written documents are to be in place at time of admission. RN is responsible for said documentation, Mgr will monitor for completion.	12/14/14

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula [signature] TITLE: Administrator (X6) DATE: 12/17/14

R167, R174 + R266 POC's accepted 12/18/14 [signature]

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R167	Continued From page 1 through 11/21/14, Resident #1 was administered Valium 11 times by unlicensed staff. Per record review on 11/24/14 there was no evidence a care plan was developed by the RN specifically for behavior monitoring, alternatives to utilize before administering the medication, specific symptoms of anxiety and monitoring for adverse effects of this medication. This was confirmed with the House Manager.	R167		
R174 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (2) Medications requiring refrigeration shall be stored in a separate, locked container impervious to water and air if kept in the same refrigerator used for storage of food. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the RCH (Residential Care Home) failed to assure medications were stored separately in a locked container in the refrigerator where food was also stored. Findings include: During a tour of the RCH with the House Manager on 11/24/14 at 9:20 AM, Latanoprost Ophthalmic (eye drop medication used in the treatment of glaucoma) was found stored in the butter dish compartment of the refrigerator where food for residents is also stored. This observation was confirmed with the House Manager.	R174	R174 New lock box was in place within the hour of discovery. Staff has been reminded of the importance of reporting and replacing broken equipment AT the time of Survey and at an in service on 12/16/14. manager will monitor monthly or as needed.	11/24/14 12/16/14

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R266	Continued From page 2	R266		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: During a tour of the RCH with the House Manager, a soiled suction machine was observed in Patient #2's room and there was a failure by staff to maintain standard infection control practices during the handling of soiled dishes. (Patient #2) Findings include: 1. Resident #2 has a past history of increased oral secretions which s/he was unable to clear due physical impairments. On 6/11/13 the RN received an order for oral suctioning using a Yankauer device (firm plastic suction tip device used in oropharyngeal secretions). During a tour of the RCH on 11/24/14 at 9:25 AM with the House Manager, a suction machine located beside the resident where s/he sat in a recliner, was noted to be soiled. The Yankauer tip was crusted with dried debris and the suction collection bottle was approximately 1/4 full with a milky colored liquid. The House Manager was unaware when the last time the resident was suctioned and acknowledged the equipment was soiled. Per review of instructions to RCH staff titled Oral Secretion Education states "Cleaning and disinfecting your equipment is simple, yet very important. Proper care prevents infection". It further discusses how to clean and store the	R266 R266	R266 As the Surveyor said this machine has not been used for an extended period of time - We are in the process of swapping out the machine for a newer one as the collection bottle itself has become cloudy. the replacement will remain sealed as well as the equipment, until it is needed. The machine will be added to the MAR for monthly inspection or daily PRN if in use. Manager will monitor MAR and equipment at least monthly or as needed if used. * we decided to keep this in-house as the	12/1/14

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R266	Continued From page 3 equipment to include the emptying of the collection bottle and cleaning or changing tubing/suctioning device. A second check of the suction equipment noted a plastic bag had been placed over the machine, however the equipment remained soiled. The House Manager was notified of the second observation and made aware that the equipment required cleaning or removal if the resident no longer required oral suctioning of secretions.	R266	Resident is NPO and end stage HD and there may be a need to use it in the future.	
	2. Per observation at approximately 10:00 AM on 11/24/14 a staff member failed to use proper hand washing and/or sanitizing after handling soiled dishes and silverware from the dining room tables after the resident's breakfast meal. When removing the soiled items, the staff member placed his/her fingers inside glasses and cups previously used by individual residents during the meal. After placing the soiled dishes on the kitchen counter, the staff member failed to sanitize or wash his/her hands and proceeded to touch with soiled hands, other objects and residents within the dining room.	R266	This caregiver was immediately reminded of universal precautions and the importance of always practicing safe handling and handwashing - We also reminded all caregivers at an In-Service on 12/16/14 Manager has made several observations of this employee since the Survey and will continue to monitor daily.	11/24/14 12/16/14